health care costs per controlled patient. Sensitivity analysis showed that the base study case was robust.

PND4

PREGABALIN VS GABAPENTIN IN THE TREATMENT OF NEUROPATHIC PAIN IN ITALY: A COST-EFFECTIVENESS ANALYSIS

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OBJECTIVE: To compare the economic impact of treating neuropathic pain with pregabalin versus gabapentin in Italy. **METHODS:** A cost-effectiveness analysis comparing costs and effects of pregabalin 375 mg/die versus gabapentin 1800 mg/die in the perspective of the Italian National Health care Service was developed. The cost effectiveness is examined alternatively in terms of the incremental cost per additional day with no or mild pain, and the incremental cost per quality-adjusted life-year (QALY) gained. Effects were derived from pregabalin randomized clinical study 1008-155 and gabapentin 645-210 and 945-211 studies. Effects are expressed as score reductions on the VAS pain scale. Pharmacological costs were quantified according to the Italian market price of the drugs; health care procedure and hospitalization costs were quantified on the basis of the National Tariff. Other health care services consumption data were derived from a Delphi Panel. To estimate daily pain experience in patients with neuropathic pain, and the impact of pregabalin and gabapentin on it, a stochastic model is used. The dynamic simulation focuses on a hypothetical cohort of 1000 patients and simulates their daily pain experience over 12 weeks, to estimate clinical and economic outcomes for the group as a whole. **RESULTS:** The cost-effectiveness ratio for the use of pregabalin is less than 1 euro per additional day with no or mild pain and €468 per QALY gained. The sensitivity analysis conducted to examine the effects of decreasing gabapentin dose to 1200 mg/die shows consistency of the model results. **CONCLUSIONS:** Although pregabalin pharmaceutical costs are higher than gabapentin costs, the analyses prove pregabalin to be more effective with a small additional cost per day with no or mild pain.

PND5

TREATMENT OF EARLY PARKINSONIAN PATIENTS WITH RASAGILINE OR ROPINIROLE. WHAT IS THE MOST COST-EFFECTIVE TREATMENT STRATEGY IN FINLAND?

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OBJECTIVE: Levodopa is the "gold standard" for the symptomatic treatment of Parkinson's Disease (PD) but its benefits decrease as the disease progresses and motor complications appear over time. To delay these complications and the need for levodopa, dopamine agonists (DAs) have been employed as monotherapy. Our aim was to perform a cost-effectiveness analysis of initiating treatment with rasagiline versus ropinirole in delaying therapy with levodopa in early PD. **METHODS:** A 5-year probabilistic Markov model simulating treatment pathways of early parkinsonian patients was used to estimate the incremental cost-effectiveness ratio of starting treatment with rasagiline or ropinirole. Transition probabilities were derived from randomized clinical trials and the effectiveness measure was the number of years until levodopa was required. Since the greatest portion of direct medical costs of early PD can be attributed to medication, the model focused on pharmacological treatment costs and more especially on pharmacy selling prices. In accordance with Finnish health economic guidelines, a 5% discount rate was applied to both costs and benefits. **RESULTS:** Beginning treatment of early PD patients with rasagiline delayed time before levodopa initiation of one year compared with ropinirole (3.8 vs. 2.8 years). Incremental cost-effectiveness was in favor of rasagiline with an ICER of €1200 per year gained without levodopa. Initiating treatment with rasagiline has a 95% probability of being cost-effective supposing that ropinirole dosage varies linearly among time. **CONCLUSION:** This economic model suggests that initiating treatment with rasagiline for early PD is more effective in delaying time to levodopa compared with ropinirole. Further studies are required to link the surrogate endpoint (time without levodopa) to final outcomes (QALY, mortality, morbidity).

PND6

RETROSPECTIVE EVALUTION OF THE DOSES OF BOTOX AND DYSPORT IN THE MANAGEMENT OF DYSTONIA—A COST MINIMISATION ANALYSIS

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OBJECTIVES: There are two preparations of Botulinum toxin type A—BOTOX and Dysport. Based on BNF prices, the dose ratio (units of Dysport : BOTOX) for cost equivalence is 4.2 : 1, however the two products are not interchangeable and there is no handy conversion factor. This study examined the dose requirements in a cohort of patients with dystonia who were stabilised first on Dysport then on BOTOX. The main objective was to evaluate the costs of each product in clinical practice. **METHODS:** Data was extracted retrospectively from case notes. Patients were included in the analysis if they had received each product for at least one year and had demonstrated a response to both. Those changed back to Dysport at any time during the 2-year period following the switch were excluded. Injections given in the 1-year period before the switch and between 1 and 2 years after the switch were included in the analysis. The mean dose of each toxin, the ratio and corresponding costs (from latest BNF) were calculated. **RESULTS:** Forty-two patients received 300 administrations. For spasmodic torticollis (36 patients) the mean doses of BOTOX and Dysport were 89 (range 53 to 120) and 397 (range 200 to 500) units respectively. The mean ratio for this indication (Dysport : BOTOX) was found to be 4.48 : 1 (95% confidence interval 4.22 : 1 to 4.73 : 1; range 2.6 : 1 to 6.3 : 1). For this indication, the mean costs per administration were found to be ≤115 and ≤122 based on units used and ≤140 and ≤153 based on whole vials for BOTOX and Dysport respectively. Similar ratios were found for other types of dystonia giving an overall mean dose ratio of 4.56 : 1 (Dysport : BOTOX). **CONCLUSION:** This study is consistent with previous work that has shown that BOTOX is associated with lower costs than Dysport.

PND7

PREDICTORS OF HEALTH CARE AND NON-HEALTH COSTS IN PATIENTS WITH REFRACTORY EPILEPSY IN SPAIN: FINDINGS FROM THE LINCE STUDY

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OBJECTIVE: To explore possible explicative variables of health and non-health costs related with patient's life and treatment